

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-045242

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

317  
FILED DEC 10 1962

500

3485

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY ST. LOUIS   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE MO. b. COUNTY ST. LOUIS                                   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN JEFFERSON BARRACKS, MISSOURI  |   | c. CITY OR TOWN BELNOR  |   |
| Length of stay in 1b<br>412 DAYS   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION VET. ADMIN. HOSPITAL  |   | d. STREET ADDRESS (If outside, give location)<br>3024 Delavan   |   |
| Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>CHARLES E. S. FITZGERALD  |   | 4. DATE OF DEATH<br>Month Day Year<br>11-26-62  |   |
| 5. SEX<br>MALE   | 6. COLOR OR RACE<br>WHITE   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br>10-25-71                                  |
| 9. AGE (last birthday)<br>91 YEARS   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>SALESMAN  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>SHOES  |   |
| 11. BIRTHPLACE (City and state or country)<br>MAYSVILLE, KENTUCKY  |   | 12. CITIZEN OF WHAT COUNTRY<br>U.S.A.   |   |
| 13a. FATHER'S NAME<br>DENNIS FITZGERALD  |   | 13b. MOTHER'S MAIDEN NAME<br>MARY SLATTERLY   |   |
| 14. NAME OF HUSBAND OR WIFE<br>NONE  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) YES SPAW   |   |
| 16. SOCIAL SECURITY NO.<br>914 Buena Vista, St. Louis, Mo.   |   | 17. INFORMANT<br>GERALD FITZGERALD (Son)  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>RIGHT INTERNAL INGUINAL HERNIA |   |   | INTERVAL BETWEEN ONSET AND DEATH<br>UNKNOWN                   |
| PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown   |   |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Hour a.m. Month, Day, Year<br>p.m.  | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    |   |   |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   | 20f. CITY, TOWN, OR LOCATION COUNTY STATE   |   |   |
| 21. attended the deceased from 10-10-61 to 11-26-62<br>Death occurred at 9:50 Pm on the date stated above, and to the best of my knowledge, from the causes stated.  |   |   |   |
| 22a. SIGNATURE<br>Emmett D. Wall<br>M.D.   |   | 22b. ADDRESS<br>VET. ADMIN. HOSP.; JEFF. BRKS., 25, MO.   |   |
| 22c. DATE SIGNED<br>11-27-62   |   |   |   |
| 23a. BURIAL CREMATION, Removal (Specify)   | 23b. DATE<br>11-29-62   | 23c. NAME OF CEMETERY OR CREMATORY<br>CALVARY   | 23d. LOCATION (City, town, or county) (State)<br>ST. LOUIS MO |
| 24. FUNERAL DIRECTOR<br>A. J. Ronnelly 3840 Rundle Ave   |   | 25. DATE RECD. BY LOCAL REG.<br>11-29-62  |   |
| 26. REGISTRAR'S SIGNATURE<br>John C. Murphy M.D.   |   |   |   |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Donna Hillison

Licensed Embalmer No. 3565

P. O. Address 3840 Lindale

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.